John Hancock
LIFE INSURANCE

Statement of Claim for Death Benefit

Telephone Inquiries: 1-800-732-5543

A message to our John Hancock beneficiaries

On behalf of John Hancock, please accept our condolences for your loss. We realize that this is a difficult time for you and your family and we will make every effort to process your claim promptly. We take pride in assisting our beneficiaries.

To expedite the processing of your claim, it is important that it contain all of the necessary information as requested in the Claimant's Statement attached.

Please review this checklist prior to submitting your claim:

- ☐ Complete all applicable sections of the Claimant's Statement. If there is more than one beneficiary, please ensure each claimant completes a Statement of Claim for Death Benefit.
- ☐ Obtain a **certified copy** of the insured's death certificate. The funeral director often provides one or assists in this area. Note: Only one certified death certificate is required per insured with multiple claimants and/or policies. *The Death Certificate will not be returned.*
- ☐ Include the original policy, if available. If the policy is not available, be sure to complete **Section G - Statement of Lost or Destroyed Policy**.
- ☐ If the claim form is being completed by an Administrator, Executor, or a Legal Guardian, a **Court Certificate of Appointment** must be submitted with this Claimant's Statement.
- ☐ If death occurred outside the United States or Canada, please submit the official death certificate issued in the country where the death occurred and:
  - A completed **Report of a Death of a U.S. Citizen Abroad**, and
  - A **Physician's Statement**, completed and signed by the local doctor who certified the death.
- ☐ Generation-Skipping Transfer Tax:
  If the proceeds are greater than $250,000.00 and are subject to the Generation-Skipping Transfer Tax, please submit a Schedule R-1 of IRS Form 706 with this Statement of Claim for Death Benefit. Schedule R-1, which is to be completed by the executor, is usually required if any part of the death benefit is payable either directly or through a trust to an individual beneficiary who is either (i) a relative two or more generations younger than the insured (a grandchild, for example) or (ii) at least 37-1/2 years younger than the insured and not related to the insured (a godchild, for example).
- ☐ Taxpayer Identification Number and Certification - All Claimants must provide their Social Security Number, Employer, Trust or Estate Tax Identification Number and complete the certification ensuring this number is correct AND indicating whether or not you are subject to Backup Tax Withholding. If this section is not answered, we are required to withhold taxes on the interest earned on the death claim proceeds.
- ☐ Review the "Fraud Warning Notices" for your state.
- ☐ If death of the insured occurred within two years of the issue date or reinstatement of the policy or supplementary benefit, further investigation will be made in order to confirm information provided at the time the application for life insurance was completed. Please ensure you provide us with a signed **Authorization to Release Information for Death Benefit** form, attached at the end of this Claimant's Statement. While we endeavor to complete this investigation quickly, it depends upon many factors that are often out of our control and we appreciate your understanding as we work through this process.

Although every effort is made to ensure prompt payment of benefits, your claim may be delayed if additional information is required to comply with the John Hancock's claim procedures for Federal and State Law. We will notify you immediately if we need additional information.

We're here to help. Should you need assistance in completing this claim, your local John Hancock representative is ready to assist you. If one is not available in your area, you may call our Customer Service toll-free number listed above.

Please note that we reserve the right to make further inquiries.

Settlement Options and Payment of Proceeds

If the policyowner previously elected a settlement option

- John Hancock is required to carry out the policyowner's instructions. We will provide the beneficiary with complete details when the claim is processed.

Payment Options for Lump-Sum Payments

- Total proceeds from one or more policies or contracts, of less than $7,500 will be paid directly to the beneficiary(ies) by check.
- Total proceeds of $7,500 or more from one or more policies or contracts will be placed in a John Hancock Safe Access Account in the beneficiary's name. This payment method also assures our beneficiary(ies) of immediate access to the claim proceeds. Please read the section below entitled "Safe Access Account" for more information.
- If the claim is payable to a corporation, partnership, multiple trustees or estate, the total proceeds will be paid by check or electronic funds transfer.

Safe Access Account

- The total claim proceeds will be deposited in a John Hancock Safe Access Account in the beneficiary's name. The Safe Access Account gives beneficiaries added peace of mind in knowing that while they take the time to make well planned financial decisions, they are immediately earning interest on the claim proceeds.

Safe Access Account offers you

Safety	John Hancock guarantees the entire account balance*.
Convenience	You can access the funds in your account at any time simply by writing a check.
Value	There are no monthly service charges or check fees.
Growth	Your account earns an attractive interest rate.
Time	Take the time you need to make well planned financial decisions.

Additional payment options

- If you reside in one of the following states - Alaska, Arkansas, Arizona, Colorado, Florida, Kansas, Maryland, North Carolina, North Dakota, Nevada, or Vermont - and would prefer not to take advantage of a John Hancock Safe Access Account, please indicate by checking the box below.

  ☐ I do not want a John Hancock Safe Access Account.

  Proceeds will be provided to you through Electronic Funds Transfer or a check. Please complete an Electronic Funds Transfer form and submit with this Statement of Claim for Death Benefit form.

- Other methods of payments may be available. A detailed explanation of available settlement options is provided in the insured's policy. If you need assistance, you can contact your local John Hancock representative. If one is not available in your area, you may also call our Customer Service toll-free number, listed on page 1.

* A John Hancock Safe Access Account is not a bank account and is not insured by the FDIC or any other government agency. Guarantees are dependent upon the claims-paying ability of the issuing company. Safe Access Account balances remain in John Hancock's general account and are subject to the claims of our creditors.

John Hancock
LIFE INSURANCE

Statement of Claim for Death Benefit

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- Complete, sign and return the form together with the insurance policy and a certified death certificate, which indicates the cause and manner of death of the insured person.
- Additional requirements may also be requested depending on the circumstances.

You, your and ***yourself*** refer to the person(s), Trustee(s) or Entity claiming the death benefit, whichever is applicable to the policy(ies).

Section A - List all policy numbers if you are claiming the death benefit for more than one policy.

1. Policy Number(s)

Section B - Tell us about the person insured by the policy(ies).

2. a) Name (First / Middle / Last) b) Date of Birth (mmm / dd / yyyy)

c) Also known as - Name (First / Middle / Last) d) Place of Birth

e) Address (Street No. & Name, Suite No., City, State, Zip code)

f) Date of Death (mmm / dd / yyyy) g) State of Residence Prior to Death h) Place of Death i) Cause of Death

j) Occupation k) Estimate Date Last Worked (mmm / dd / yyyy)

l) Employer's Name

m) Employer's Address (Street No. & Name, Suite No., City, State, Zip code)

Section C - Read this section carefully if the named beneficiary(ies) is not alive.

3. If the last known beneficiary(ies) of the policy(ies) has died, please send us a copy of the beneficiary's death certificate.

Section D - Tell us about the claimant of the death benefit proceeds (i.e., individual, company, executor or trustee, whichever is applicable for this policy(ies)).

4. a) Name (First / Middle / Last) b) Gender ☐ Male ☐ Female

c) Street Address (Street No. & Name, Suite No., City, State, Zip code)

d) Mailing Address (if different than Street Address) (Street No. & Name, Suite No., City, State, Zip code)

e) Date of Birth (mmm / dd / yyyy) f) Relationship to Insured

g) Tel Nos. (Home / Business) h) E-mail Address

i) Best time to Call at ☐ Home ☐ Business j) Fax No.

Section D - Tell us about the claimant of the death benefit proceeds (i.e., individual, company, executor or trustee, whichever is applicable for this policy(ies)). (continued)

4. k) In what capacity are you claiming the death benefit?

- ☐ Executor or Administrator - Please send a court certificate of appointment.
- ☐ Legal Guardian - Please send a court certificate of appointment.
- ☐ Named Beneficiary - Please complete one form for each named beneficiary.
- ☐ Trustee
- ☐ Other Specify

If former spouse, please include copy of divorce settlement.

5. Generation-Skipping Transfer Tax - Are the death benefit proceeds subject to the Generation-Skipping Transfer Tax? ☐ Yes ☐ No

If you answered Yes above, and the proceeds are greater than $250,000, please submit a Schedule R-1 of IRS Form 706.

Section E - Additional Information

1. Complete if any family members are covered under the insurance being claimed.

Please list the names and birth dates of all children born of the marriage of the insured and the insured's Spouse, or of children acquired by the insured as stepchildren or legally adopted children. Please list only living children who have not reached their 25th birthday.

Full Name of Child/Spouse	Relationship to Insured	Social Security Number	Birthdate mmm	dd	yyyy	Gender (M/F)

Is there any possibility of a posthumous child (a child born after the death of the father)? ☐ Yes ☐ No

Section F - Read this section carefully and complete it ONLY if you are a trustee of the trust that is claiming the proceeds of this policy(ies).

1. a) Name of Trust

b) Date of Trust mmm dd yyyy

If more than one trustee, all trustees must complete and sign this form.

c) Name of Trustee(s)

Certification

If you have completed this section, you are making the following commitments when you sign this form:

- You certify that you are the trustee(s) of the trust named above.
- You certify that you have the right under the trust to act as the claimant for the policies named in this form.
- You agree that John Hancock doesn't have to determine the original terms of the trust or any revisions to them. You also agree that John Hancock shall not be charged with the knowledge of the trust's provisions. You confirm that neither John Hancock nor its representatives are responsible for inquiring into or shall be charged with the knowledge of the terms of the trust.
- You agree that John Hancock may discharge its obligations under the policies named in this form by relying solely on the signature of the trustee(s) or successor trustee(s) on this form.
- You agree that proof of payment to the trustee(s) of the death claim proceeds will be final and conclusive evidence that payment was made and that all claims and demands of the trustee(s) against John Hancock will have been satisfied.

Section G - Statement of Lost or Destroyed Policy

Check this box if the policy is lost or destroyed:

☐ The undersigned hereby represents that the above numbered policy was lost or destroyed. This policy is not now assigned, nor has it been otherwise transferred or encumbered in any manner. No person, firm or corporation has or claims the right to possession of this policy.

Section H - Request for Taxpayer Identification Number and Certification

☐ Check this box only if you are not a U.S. Citizen or resident or otherwise not subject to U.S. taxation, and complete an IRS W-8BEN form instead of completing the remainder of Section H below.

☐ For Minnesota residents only - Check this box if you are a Minnesota resident and have completed the IRS Form W-9. (You are not required to submit this form to John Hancock.)

Social Security Number ___ ___ ____

Employer, Trust or Estate Tax Identification Number ___ _____

In order to comply with IRS regulations regarding Tax Identification Numbers and Backup Tax Withholding, individuals and sole proprietors MUST give their Social Security Number if they are claiming the death benefit proceeds on this policy(ies). Other entities MUST give their Employer Identification Number.

ALL claimants must complete the certification question below and sign this page.

If you have no number or you have applied for a number and are waiting for one to be issued, write "Applied For" in the boxes. You then have 60 days to supply your Tax Identification Number to us. After 60 days, if no Tax Identification Number has been provided, John Hancock must begin backup withholding on certain payments, such as interest, that are subject to income tax. Life insurance death benefits generally are not subject to income tax nor to backup withholding.

Certification - Under Penalties of Perjury, I certify that:

The number shown on this form is the correct taxpayer identification number for the individual/entity claiming the proceeds (or I am waiting for a number to be issued) AND

Please check one of the following in order to receive the death benefit proceeds:

☐ I am NOT subject to Backup Tax Withholding because:

a) I am exempt from Backup Tax Withholding, or

b) I have not been notified by the IRS that I am subject to Backup Tax Withholding as a result of a failure to report all interest or dividends, or

c) The IRS has notified me that I am no longer subject to Backup Tax Withholding. (Does not apply to real estate transactions, mortgage interest paid, the acquisition or abandonment of secured property, contributions to an individual retirement arrangement (IRA), and payments other than interest and dividends).

☐ I am subject to Backup Tax Withholding.

Also, please check the applicable boxes: ☐ I am a U.S. person (including a U.S. resident alien)

Each claimant must sign a separate certification.

Signed at City State | This | Day of | Year

Signature of Claimant, Trustee(s), Executor or Signing Officer

x

x

x

Section I - Form 712 (Life Insurance Statement)

☐ Please check this box if you require an IRS Form 712 (Life Insurance Statement).

FRAUD WARNING NOTICES - PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with the intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the Company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars ($5,000.00) and the stated value of the claim for each such violation.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false or deceptive information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ALL OTHER STATES: Any person who knowingly and with intent to defraud any insurance company or other persons, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, subject to criminal prosecution and/or civil penalties.

Section J - All *Individual* claimants or trustees must sign here and have their signature witnessed by a disinterested third party.

Any person who knowingly and with intent to defraud any insurance company or other persons, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, is subject to criminal prosecution and/or civil penalties. By signing below, you agree under penalties of perjury that the information in this statement is complete and true to the best of your knowledge (please sign as you would sign a check). Refer to "Fraud Warning Notices" insert for your state.

Signed at (City, State) | This | Day of | Year

Signature of Claimant #1 | Signature of Witness

Signature of Claimant #2 | Signature of Witness

Signature of Claimant #3 | Signature of Witness

Section K - Signatures - All *Corporate* claimants must sign here and have their signature witnessed by a disinterested third party.

Any person who knowingly and with intent to defraud any insurance company or other persons, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, is subject to criminal prosecution and/or civil penalties. By signing below, you agree under penalties of perjury that the information in this statement is complete and true to the best of your knowledge (please sign as you would sign a check). Refer to "Fraud Warning Notices" insert for your state.

Corporations making a claim must provide either: • The title and signature of one signing officer along with the corporate seal, or
• Signatures of two signing officers with their titles and the Corporation Name.

Signed at (City, State) | This | Day of | Year

Signature of the First Signing Officer | Signature of Witness

Name and Title of the First Signing Officer and the Name of Corporation

Signature of the Second Signing Officer | Signature of Witness

Name and Title of the Second Signing Officer and the Name of Corporation

By providing this form or other claim forms for the convenience of the claimant, John Hancock does not admit any liability or waive any of its rights.

John Hancock
LIFE INSURANCE

Authorization to Obtain and Disclose Information for Death Benefit

This form is required when:
- The policy or policy provision was issued or reinstated within two years of the Insured's death.
- The policy contains an Accidental Death Benefit provision and there is a possibility that death was caused by accidental bodily injury.

This form may also be required for other cases.

Tell us about the doctors, hospitals and institutions who treated the insured in the past. (use a separate sheet if necessary).

1. Name of Doctor, Hospital or Institution

Address (Street No. & Name, Suite No., City, State, Zip code)

Condition Treated

Date of Treatment (mmm / dd / yyyy)

2. Name of Doctor, Hospital or Institution

Address (Street No. & Name, Suite No., City, State, Zip code)

Condition Treated

Date of Treatment (mmm / dd / yyyy)

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the MIB, Inc., formerly known as Medical Information Bureau, consumer reporting agency, or employer, having information available as to diagnosis, treatment and prognosis, with respect to any physical or mental condition or treatment of:

Name of Insured (First / Middle / Last)

Date of Death (mmm / dd / yyyy)

Authorization - Please Read Carefully Before Signing

I hereby authorize the following uses and disclosures of health and non-medical information about the Insured (HIPAA Compliant Authorization).

1. The *health information* that I authorize to be used or disclosed consists of all the following information:
   (a) *The Insured's medical records and medical history;* and
   (b) Other information that relates to:
      (i) the diagnosis, treatment or prognosis of any physical or mental condition;
      (ii) records from coroners and medical examiners, including autopsy and toxicology results, whether such information is in electronic or paper form. This includes, but is not limited to, information related to psychiatric or psychological conditions; prescription drugs; alcohol or drug abuse; communicable or infectious conditions such as AIDS, or sexually transmitted diseases.
2. The following persons or entities are authorized to disclose health information about the Insured: licensed physicians; medical and dental practitioners; coroners; hospitals; clinics; pharmacies; other insurance companies; medical or medically-related facilities; and any reporting agency such as the MIB, Inc. that has any records or knowledge regarding the Insured.
3. The *non-medical information* that I authorize to be used or disclosed consists of any information related to the following: driving and aviation; avocations and habits; other insurance coverage; education; finances, including income tax records; law enforcement, court and military records; and any business records associated with the policy(ies) to which the claim relates.
4. The following persons or entities are authorized to disclose non-medical information about the Insured: law enforcement agencies; state and local tax agencies; other government agencies such as the Workers' Compensation Board and the Social Security Administration; other insurers; certified public accountants and tax preparers; banks and financial institutions; consumer reporting agencies; and educational institutions.
5. Health and non-medical information about the Insured may be disclosed to John Hancock and its affiliates, service providers, reinsurers, any consumer reporting agencies and to the MIB, Inc.
6. Health and non-medical information about the Insured may be used or disclosed to evaluate or process any claim for life insurance benefits. I understand that there may be additional uses or disclosures of the Insured's health and non-medical information that are specifically permitted by law without my authorization.

Authorization to Obtain and Disclose Information for Death Benefit (continued)

I understand that:

- My failure to sign this Authorization may affect John Hancock's consideration of my claim for payment of benefits.
- Although an authorization may generally be revoked by sending a written request to John Hancock, there is no right to revoke this Authorization if my claim for benefits may be contested by John Hancock or if John Hancock has already relied and acted upon this Authorization.
- The Insured's health and non-medical information may be redisclosed and no longer protected by applicable law. John Hancock does, however, require its service providers to protect the confidentiality of health and non-medical information.
- A photocopy or facsimile copy of this Authorization is as valid as the original.
- I am entitled to receive a true copy of this signed Authorization.
- This Authorization shall remain in effect for the duration of the claim process, unless the process *exceeds one year from the date of my signature below*. I also agree that John Hancock, by using this authorization to obtain information, represents that the duration of the claim has not expired.
- This Authorization is required so that John Hancock, its reinsurers who have assumed part of the risk and others who perform business or legal services may obtain and use such information to evaluate eligibility for payment of benefits under the policy(ies) to which the claim relates or as otherwise authorized or required by law.

I authorize the Social Security Administration to release to John Hancock or its authorized representatives detailed earnings for up to the last 10 years and/or summary record of total earnings and/or information from master benefit records regarding award, denial or continuing benefits. I understand that this information is to be released to properly adjudicate my claim.

I am the Insured's legal representative of estate, survivor or individual with material interest. I understand that any person who, knowingly and with intent to defraud or deceive any insurance company, makes any representation which I know is false to obtain information from federal records, could be punished by fine, imprisonment or both.

Signature

x

Date

Name - Please print

Relationship to the Insured (Deceased)

NOTE: If this Authorization is signed by the Insured's personal representative, please include a Court Certificate of Appointment naming the executor or administrator of the estate.

Please complete the following section if applicable: An estate representative has not been appointed for the above deceased. Furthermore, there are no plans to have an estate representative appointed and I am in charge of the deceased's affairs. I am the next of kin of the deceased and I authorize the release of all medical records pertaining to that person to John Hancock or its representative.

Signature of Next of Kin

x

Date

Name - Please print

Relationship to the Insured (Deceased)